

Dept. Health,
 & Welfare
 J. S. Public
 Health Service

FILED DEC 13 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

42600
 STATE FILE NUMBER
 11535

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

V. S. 300
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <i>St. Louis</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>St. Louis</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Homer G. Phillips</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>4447 Page Blvd</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>L.</i> Last <i>Shanks</i>			4. DATE OF DEATH Month <i>11</i> - Day <i>27</i> - Year <i>57</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-9-96</i>	9. AGE (In years at birthday) <i>60</i>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <i>unk.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>Charles Shanks</i>		13b. MOTHER'S MAIDEN NAME <i>Nara Brown</i>		14. NAME OF HUSBAND OR WIFE <i>Susan Shanks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>489-03-6381</i>	17. INFORMANT Address <i>Susan Shanks 4447 Page</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> <i>Cardiac Hypertrophy</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>434.3</i>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <i>8:00 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>James M. Keeley, Deputy Coroner</i>			22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>11-30-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-4-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Washington Park</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Mo.</i>
24. FUNERAL DIRECTOR <i>Jackson Funeral Home 2649 Delmar</i>		25. DATE RECD. BY LOCAL REG. <i>DEC 2 57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>	

securing the medical certification in the specific manner required by 1957, 40 WORS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Leroy U. Dannerster*

Licensed Embalmer No. *4523*
P. O. Address *4251 Washington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.